Green College Lectures

The National Health Service versus private and complementary medicine

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My views are those of a consultant who worked for 33 years in the NHS since its inception and in private practice for rather longer.

Background

From its inception in 1948 the NHS was by virtue of its pay beds the largest provider of private short term medical care in Britain, a position it maintained for more than a quarter of a century. Many former voluntary hospitals had private beds—in some only a few, in others a whole floor or even a separate building. Although considered socially divisive by some people, these beds met the needs of certain British patients, who were eligible for treatment in the public wards of the NHS, and of overseas patients, often expatriates working in the Commonwealth, who were not.

The Act of 1946 gave general practitioners and hospital consultants the right to private practice. Many general practitioners forwent this right. Others ran NHS and private practices in tandem but after a while stopped taking private patients. A few, notably in London, confined themselves to private practice only. The decision for consultants was more difficult. Those in middle life on the appointed day were accustomed to holding an honorary (unpaid) appointment at their voluntary hospital. They were unsure of the implications of a salaried, particularly a full time salaried, service. Would it jeopardise their clinical freedom? In the event most were offered only part time contracts and hence continued in private practice. Many of my generation thought that much of the best clinical and research work was done by full timers. Permanent academic or full time NHS appointments were few and far between, however. When the time came for me to move on from the Postgraduate Medical School at Hammersmith only seven sessions were available at Westminster Hospital and private practice had to fill the remuneration gap.

Until the early 1970s there was a steady state between the NHS and private medicine. Many consultants were geographically whole time, to their hospital's advantage. Often they would visit their pay bed patients outside the normal hours of duty and invariably inquired of their junior staff if there were any problems in the public wards.[1] Outside the NHS were a number of non-profit making religious or charitable private nursing homes which fulfilled an important but limited function because many of us thought they were not the right place for very seriously ill patients or for major surgery.

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A decade of change

In 1974 boards of governors and hospital management committees were disbanded. Both had done much to interest the community in *their* hospital. Such bodies were perhaps an anachronism, but much that is good in British public life is anachronistic. Our board members were astute, outstanding people from many walks of life who gave their services free. We lost, for example, the wise counsel of the chairman of ICI and many others who were actual or potential users of our pay beds and did much to maintain high standards throughout the hospital.

Worse was to come with the aversion of the Labour government to private practice in the NHS and the declared intention in 1976 of phasing out the pay beds.

Growth of the independent sector

To avoid ambiguity I shall call non-NHS hospitals for private patients "independent" and those equipped with an operating theatre "acute." The primary factor that led to the increase in the number of acute independent hospitals during the past 10 years was the shortcomings of the service provided by the NHS. Despite the temptation it is not my intention to join the chorus of analysts who have in recent months defined these shortcomings and the reasons for them and suggested how they might be remedied. Rather I wish to point out the consequences of these shortcomings; how they have affected patients and also the medical and nursing professions.

Between 1979 and 1987 the number of independent hospitals increased in England and Wales from 139 to 188, and the number of independent beds from 6316 to 9675 (J B Randle, personal communication). Currently the NHS has some 3000 pay beds. The reasons for this growth in the independent sector are several.

NHS pay beds are an unrealised and unappreciated asset. Although specifically debarred from making a profit, many NHS administrators seemed unaware that their pay beds cost more to run than the income received from them (J B Randle, personal communication). The private sector of the NHS has been allowed to run down. Consulting rooms for seeing private patients are often poorly appointed. Many pay bed rooms are substandard without lavatory, shower, or bath, and lack amenities that cannot now be considered luxuries. It is questionable whether hospital managers have the commercial experience or the access to capital funds to reverse this trend.

By 1985 the NHS waiting list for non-urgent admissions had grown to 800 000. What is classified as non-urgent may be perceived differently, for example, by a woman with alarming (to her) menorrhagia. Patients may have to wait six weeks or more before getting a hospital appointment as an outpatient. When the patient is eventually seen all too often a second or third visit is required for relatively simple investigations before the patient is seen by the consultant again or sometimes, unhappily, by a different doctor. To circumvent these delays by using the private facilities of the NHS is

to invite the accusation of queue jumping. Undoubtedly, NHS outpatient clinics are overused. In 1985 there were nearly 62 million outpatient attendances—on average more than one attendance for every member of the population. Why are there such wide differences in the number of patients referred to hospital by individual family practitioners?[2] Follow up clinics would be an appropriate subject for quality assessment; they can be exasperating for patients who may see a different doctor unfamiliar with their problem at each visit.

The quest for economy and increased bed use has led to some unhappy consequences. Consultants used to have all their patients in two wards—male and female. Here a close team spirit was established between the doctors, the ward sister, her staff, and the social worker. Now our patients may be scattered through as many as 10 different wards, each designated to some specialty. This haphazard distribution reduces the team spirit and liaison between the doctors and nurses who feel that interlopers are infringing their territory. Furthermore, the supervision of patients in many different wards is less easy for the house staff.

Patients, or their attitudes, have changed. No longer are they the submissive recipients of charity or tolerant of paternalism. From taxation they are paying for *their* much loved health service. Education and television (don't blame just the profession for this) have heightened their expectations. To meet the inevitable demand for quicker private care nursing homes have been upgraded to hospitals and new hospitals with facilities equal or superior to those in NHS hospitals have been built. The independent sector now carries out more than a tenth of all major short term hospital care and some 500 000 operations yearly. One quarter of all hip replacement operations and one fifth of all operations for heart disease are done by the independent sector (J B Randle, personal communication).

The proportion of all beds in the independent sector has fallen in religious and charitable hospitals from 72% in 1979 to 47% in 1987, although the overall number of beds has remained the same. By contrast the proportion of all beds has increased over the same period in the for-profit hospitals from 28% to 53%, and the number of beds in acute for-profit hospitals has risen from about 1800 in 1979 to 5300 in 1985. To me there is something slightly distasteful about running a hospital for financial gain, but one must be realistic: the money for new equipment and better facilities has to come from somewhere, and in the end it is the patient who mainly benefits. To meet the cost of private care some six million people (12% of the population) are insured, and only a fifth of those using independent hospitals are uninsured. Today private insurance embraces a wide range of society including many of the medical profession.

The pros of acute private care

To the patient the advantages of private care are several. Diagnosis and treatment are usually achieved more quickly, and in non-urgent cases elective surgery is done at a predetermined time which is convenient to the patient, the family, and the consultant. To many people the assurance that the treatment will be carried out by a particular consultant is the overriding consideration. In most instances the consultant is not chosen at the whim of the patient[3] but with the guidance of the general practitioner. The overall standard of care is usually as good or better and the length of hospital stay less than in the NHS. Most patients sleep better and are more at ease in a private room.

From the point of view of doctors financial incentives are not the only nor necessarily the main reason for engaging in private practice. Such work brings them in closer contact with patients and improves communication to the benefit of both. The history is not read out by a house officer or medical student. The consultant can give more time. There is greater job satisfaction.

Private work must be carried out in a scrupulously honest way, and in most instances it is. Consultants must continue to meet more than their strictly contractual NHS commitments. Whether they use NHS pay beds or an independent hospital it is surely wrong to write about private patients on hospital notepaper, to make use of the hospital postage franking machine, or to ask the NHS secretary to type the letter in hospital time. Worse still is to use without charge NHS facilities to investigate a private patient.

The cons of acute private care

Unbeknown to the patient things may go wrong and the independent hospital lack the necessary facilities. In practice this is rare because the wise consultant, whose reputation is at stake, will admit the potentially "difficult" patient only to an independent hospital of the right calibre. It is not uncommon to move before the operation a surgical patient with perceived anaesthetic or medical risks to an NHS pay bed or another independent hospital where there is intensive care.

At night in NHS hospitals there are highly skilled, if sometimes exhausted, junior staff on duty. In the private sector a resident medical officer, often studying for a higher degree, is usually on call. The recent report on perioperative mortality in three NHS regions, however, gives examples of junior staff carrying out operations that have proved fatal without seeking the advice of their senior registrar or consultant before, during, or after the event.[4]

In the independent hospital the consultant lacks the critical comments of his junior staff, and there are no students to ask difficult questions. Nor is there peer review, although this is less applied in the NHS than it should be.

The growth of the independent sector has had the disadvantage that many consultants with part time contracts have ceased to be geographically whole time. To travel between an NHS and an independent hospital is uneconomical of time. No longer may the consultant lunch, as was his wont, with his colleagues at his NHS hospital. Indeed, no longer may a separate consultants' dining room exist. Such was not elitism but served a useful purpose because many medical and administrative problems can be settled over a meal.

NHS versus private acute medicine

Is there really conflict between the NHS and private or independent medical care? I have always looked on them as complementary. The independent sector offers a measure of quality control in patient care and certainly in hospital management. Surely the activity in the independent sector—500 000 operations yearly—must relieve some of the pressure on the NHS? Collaboration between the two has proved fruitful in the use of expensive equipment such as magnetic resonance imaging and lithotripsy. Other beneficial cooperation is certainly possible.

We must keep our perspective. In 1987 the NHS spent £21 500m (£380 per head) on health care but, ignoring consumer spending on pharmaceuticals, etc, only £1500m (£26 per head) was spent on acute private care—a mere 7% (J B Randle, personal communication).

Has expansion of the acute independent sector been damaging to the nation's health? Is there evidence that more unnecessary procedures are done in the private sector than in the NHS? In Britain there are no data to compare the performance of the two sectors. It is hard to believe, but true, that the number of hospital "deaths and discharges" are recorded by the NHS as an undifferentiated figure from which it is impossible to tell how many patients died and how many lived, and of those discharged alive how many were cured, improved, unchanged, or worse when they left hospital.

One can only say that in comparison with certain other industrialised countries the health of our nation is not good. Per head of population more people in England and Wales die of lung cancer and obstructive airways disease than in Japan or the United States. More people die of ischaemic heart disease, all forms of cancer, and strokes than in those countries.[5] Nor, with the exception of Finland, do we compare favourably with other European countries in mortality from ischaemic heart disease.

Long stay care: the elderly and mentally handicapped

Apart from carrying 10% of the acute medical and surgical care in Britain, more than 40% of long stay patients are accommodated in the independent sector, and this relieves the NHS of an enormous hidden burden in the long term care of the elderly, the chronic mentally ill, and the mentally handicapped. Some 10 000 mentally handicapped and 4500 chronic mentally ill patients are cared for privately.[6] More important numerically are the elderly. In 1986 some 139 000 elderly patients in England were cared for in the private sector as compared with 151 000 in local authority or NHS geriatric accommodation (J B Randle, personal communication).

The costs in the public and private sectors vary considerably, being in November 1985 £177 per week in local authority residential homes, £284 a week in NHS long stay hospitals, and £153 in private residential and nursing homes.[7] These differences are currently under the scrutiny of Sir Roy Griffiths. Many elderly patients at a cost of £10 000 a year or more are paid for out of taxed income by their relatives. Even allowing for the payment of attendance allowances or supplementary benefits the "saving" to the government of private care for the elderly is of the order of £1000m a year (J B Randle, personal communication).

Complementary medicine

There are several reasons for the current increased interest in complementary medicine. Orthodox medicine can deal successfully with many bacterial, endocrine, and metabolic diseases, but there is a hard core of chronic intractable disorders that cannot be cured though many can be relieved.[8] The public is fearful of drug toxicity. Orthodoxy and authoritarianism are out of fashion.

Complementary is the right word. Most patients use unconventional treatments to complement, rather than as an exclusive alternative to, orthodox medicine. When seriously ill they often revert to orthodoxy. Leaving out blatant charlatanism, the main choices are acupuncture, hypnosis, homoeopathy, osteopathy, chiropraxy, herbalism, and megavitimins.[9] None is new, and the number of widely different techniques on offer taxes scientific credibility. The same standards of assessment should be used to determine the efficacy of complementary as of orthodox medicine and drugs.[10 11] When such trials are carried out, the results are usually uncomplimentary.[12]

The major successes of the unorthodox lie in musculoskeletal disorders, the relief of unexplained pain, behavioural problems, addictions, and symptoms that have their origin in psychoneurosis. Most practitioners of complementary medicine are convinced of the value of their particular technique and convey this enthusiasm to the patient. They may give more time to their patients; they tend to listen and communicate well.

Homoeopathy has a reputation of success largely, in my view, owing to the personality of those who practise it. For many years I worked in tandem and harmony with a distinguished homoeopath who was an outstandingly good doctor. When the patient's sputum became purulent she suggested I prescribed an antibiotic. When she gave a homoeopathic preparation to "bring out" the spots of chickenpox I prescribed an antihistamine to stop them itching. When a patient developed thyrotoxicosis she conceded that homoeopathy had nothing to offer, and carbimazole was prescribed.

Herbal remedies are not as innocuous as the public think. They may be fortified with potent drugs, and the medical press contains an increasing number of reports of serious side effects from "natural" herbs.[13-15] The Committee on the Safety of Medicines will review some 700 herbal products in the years to come and those recommended for serious conditions, such as hypertension or depression, will have to show proof of efficacy and safety.[16]

Unqualified practitioners may cause much distress. A patient with backache, in whom metastatic cancer or myeloma had been specifically excluded, went with his *x* ray films showing clear evidence of degenerative arthritis to an unqualified osteopath, who viewed the *x* ray films in front of the patient and his wife and said: "You know you've got cancer—riddled with it." In the event it was not difficult to restore the patient's confidence and assuage his wife's anxiety. He remains alive; his backache is tolerable.

We can live with complementary medicine but should be concerned about medically qualified practitioners who despite their scientific training ascribe all ills to food allergy, pesticide poisoning, or deficiency of a trace mineral. Such misconceptions are not new. Fifty years ago patients were having a variety of symptoms allegedly due to "visceroptosis" cured by surgery.

A final word

The NHS is unique. Despite its present problems it is too good to be starved to death either from lack of funds or by inept husbandry on the part of administrators or the medical profession. The task of managers at district and regional levels is not easy on a fixed budget. Can a manager of a successful store in, say, Birmingham, who is not permitted to alter the selling price of his goods, be expected to increase his profit next year when he is required to pay his shop assistants 9% more and expected to refurbish his display counters and instal new computer tills at the checkout points? The medical profession can to a limited degree help. We can do more day surgery. We are well aware that there must be some form of rationing, some order of priority. Clinical freedom is relative, not absolute. For years it has been restricted by the available resources and ethical considerations. I would not quarrel with the limited drug list. But there is a limit below which we cannot for many patients curtail the length of hospital stay because of humanitarian and biological reasons.

The NHS is a precious jewel in our crown and close to the hearts of the British public and the health care professions. One senses the electorate will accept, even welcome, a mixed medical economy, provided, and this is an important proviso, the NHS is improved and "free" medical care continues to be available at the time of need.

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